DATE (*rec'd by DME call)	MCO	CODE OR Dx (Search by CTRL-F)	Issue ALPHABETICAL BY ISSUE	ISSUE Detail SHADED AREAS ARE CONSIDERED CLOSED	MCO RESOLUTION NOTES W/DATE, SHADED IF CLOSED SHADED AREAS ARE CONSIDERED CLOSED
8/20/13	UHC SUN AME	B4150-B4160	Allowed Charge	Each code a flat rate, whereas the calorie content and cost of the specific Brand within each code varies widely. Reimbursement is negative in many cases due to this variance.	9/11/13 State has requested invoices from providers, and to date have received none. Will continue researching policies and rates related to Enteral codes. 9/26/13 State has requested invoices 10/8/13 no invoices received to date
8/20/13	SUN AME	B9998	Allowed Charge	Reimbursement varies. Allowed vs. not-allowed	8/30/13 AME researching 9/24/13 SUN-We have reprocessed J1642 claims, E0780 claims and some B9998 claims 10.4.13 AGP | There were a number of claims denied by an analyst incorrectly. A claim project has been submitted for those claims with an ECD of 10.27.13. Reimbursement rates will vary for the B9998 because pricing is based on invoice and as a provider's cost varies over time/order so will reimbursement. 10/14/13 SUN It is our policy to pay the lesser of the 3 options and is a documented work process. We will need to pull each invoice associated with the members/claims and research how the services were paid. We will review these, determine if additional training is needed and get back to you. will have target resolution date by 10/18 10/14/13 SUN: Some B9998 claim will require manual review, which is underway. 10/29/13 SUN will manually review for pricing. 11/7/13 SUN review of the this provider's B9998s were completed last night and we are sending claims back for processing as necessary. Some were denied in error when invoice was present and we are doing internal claims team education to prevent this in the future globally. 11/15/13 SUN: Provider has sent us a spreadsheet after reviewing our report, and we expect to have all B9998s at issue reprocessed by end of this week. 12/3/13 AGP: Continuing to work to resolve remaining adjustment issues. Anticipate final project submission late this week, or early next to complete cleanup of outstanding claims.

8/29/13*	UHC SUN	All	Allowed Charge	MCO stating they are utilizing the State max allowed price, on Medicare crossover so not paying any additional, sometimes only paying $3. Allowed charge on SUN RA is far below MCR & MCD allowed charge	9/10/13 State, Verifying fee schedules and allowed amount, need provider examples 9/24/13 UHC We have two global projects surrounding COB that would impact the DME providers. One is to adjust overpayments when UHC did not COB on claims were we should have or when we did we did not calculate the payments correctly. The second project is specific to DME and the policy clarification provided by Jason a few weeks ago. This policy indicates the DME services and supplies should be exempt from Medicare part B editing. We are in the process of getting that configured. All providers impacted by either issue will have claims adjusted if they were impacted, no ETA given. 10/7/13 SUN: For Medicare crossovers, system reconfiguration will be necessary. We are applying State Medicaid rate, not MCR rate. re-configuration analysis eta 10/31, then begin claims reprocessing, no eta yet. 10/7/13 SUN: System reconfiguration will be necessary, eta 11/1/13, then 30-60 days for claims processing completion. new day claims should be processing correctly. 10/8/13 UHC • COB related overpayments – Letters were mailed to providers on 9/18, it takes approximately 75 days (45 day hold period and 30 days to adjust) to complete overpayment projects, new day claims should be processing correctly this week, and will begin claims adjustment project, no eta yet. 10/29/13 Verifying Medicare Crossover CR status. 11/18/13 UHC: COB overpayment recoveries are still in process. Claims overpaid between 1/1/2013 and 7/1/2013 are on schedule to be completed by 12/15/2013. Claims for dates of service after 7/1/2013 are being capture through normal monthly account recovery activities. Providers can expect a 75 day timeline for those from the date of the letter they receive unless they waive their 45 day "hold time". 11/18/13: SUN continuing to work on CRs to update system configuration. 12/2/13 SUN: Targeting release of CR to update system 12/6/13.
8/23/13	TBD	E0570RR E0572RR	Allowed Charge	Nebulizer used to be reimbursed at $20/mo x13 months then was considered owned (payment stopped). Now gets $16/mo x2 mo then payment stops.	Providers: please provide specific examples, appears to be following state allowance

8/28/13	UHC SUN AME	K0739	Allowed Charge	Low reimbursement	MCO following state allowed charge of $7.50
11/5/13	UHC	T4521 T4525 T4530	Claims-	non-payment of these codes	11/18/2013 - UHC - per state policy coverage for diapers is limited to 6 units per day and a max payment of $150.00 per month. We will need to work with this provider on these individual claims to validate if claims were processed correctly. 11/27/2013 - UHC - We have been working with provider on this item. It does appear that this provider's claims processed incorrectly. We are researching whether or not this is an isolated issue related to an individual claims processor or if we have a system issue.
8/29/13	SUN	B4035	Claims- Audits	Claim denied "after review of claims history". Previous and subsequent claim paid. Help desk stated it was denied by a random audit process and they would have to appeal to a PO BOX in Missouri. Questioning audit process and lack of consistent coverage guidelines.	9/9/13 SUN, This is standard messaging used for denials related to SSHP code edit software. Claims would need to be appealed with supporting documentation to SSHP Attn: Reconsiderations PO Box 4070, Farmington, MO.

10/10/13	SUN	J3370	Claims- coverage	MCO requiring use of GR for gram instead of GM	10/24/13, state, please follow each MCO's instructions on billing. GR is the industry standard abbreviation for gram on the 837 transaction. The 837 transaction is the HIPAA compliant standard used to bill HCPCS. The NDC information being requested with the HCPCS is required. Regarding these same drugs dispensed to FFS beneficiaries, you can continue to use the NCPDP transaction. The NCPDP transaction is the HIPAA compliant standard for billing NDCs.
10/16/13	AME	A4627	Claims- coverage	How often can this code be billed/paid	2 every 180 days

8/29/13*	AME UHC	E0607 A5063 A4406 A4310 A4338 A4409	Claims- coverage	Some nebulizers purchase covered, some not. General explanation “submitted service not allowed per contract”. Inconsistent coverage. (Usually for children). Pouches and waifers for ostomy supplies not covered	8/29/13 UHC needs claim detail 9/10/13- UHC has requested but not yet received claim detail 9/12/13 UHC need claim detail 9.26.13 | AGP - Review on-going results expected in early October. 10.4.13 AGP | This is a configuration issue where the in-network agreement did not correctly migrate after the continuity of care period. The configuration is being amended to allow payment of claims. A claim project to reprocess the claims will be made upon completion of the configuration update. ECD on update is 10.15.13 and claims ECD 10.31.13. This issue is not code specific but rather fee schedule/configuration related. 10/8/13 UHC has requested by not received claim detail 10/14/13 PROVIDER, please provide claim detail to UHC 10/22/13 State: Provider verified she has no outstanding issues regarding E0607 with UHC 12/2/13 - AGP | Spoke with provider and they believe all issues resolved - have provided additional call information for future contact if necessary.
8/29/13	SUN UHC AME	J1642	Claims- coverage	Inconsistent coverage- allowed vs. not allowed & inconsistent reimbursement amounts	9/24/13 state researching coverage requirements. 9/30/13 J1642 is not covered for provider type 25-250 DME/Medical supply dealer under FFS

9/6/13	AME	90736	Claims- coverage	Rx Rejecting as not a covered service	9/9/13 Claim was denied because she is a non-par provider. PR advised provider to become contracted and requested W-9 along with provider contact information for the Contracting Rep to reach out to provider. According to AMA 2013 CPT Manual that the code for a live vaccine is 90736
8/29/13	UHC	A4554	Claims- coverage	HCBS FE waiver claims being denied. (was T2029 code)	9/11/13 UHC We are initiating changes to our system based on this clarification but it will take several weeks to get these changes made. Once the system update are made we will do a global project to identify claims and reprocess them. If individual providers do not want to wait for the global project we can work with them to get claims adjusted. New day claims will not process correctly until the systemic correction is made. 9/12/13 UHC, 9/12/13 UHC, outstanding global issue, working on a fix so A4554 can be billed with incontinence Dx only per State guidelines, No ETA 10/8/13 - UHC - System configuration for A4554 was corrected on 9/23/2013. We are in the process of getting all impacted claims adjusted. eta for claims adjustment completion for A4554 is end of Nov. 10/8/13 UHC A4554 adjustments completion 11/8/13 10/22/2013 - New day claims for A4554 should be processing correctly as of 9/23/2013. Adjustment should be completed by 11/15/13. UHC - the adjustment project for UHC was completed on 10/15/2013. This issue should be resolved for providers.

8/29/13*	SUN	G0333	Claims- G codes	G codes not paying	9/9/13 SUN, still trying to contact provider for claim examples 9/10/13 SUN, G0333 issue being researched 9/24/13 SUN: Claim examples received and under review. 10/7/13 SUN: For G0333, system reconfiguration work completed as of 9/27/13. claims adjustment no eta 10/8/13 AME will f/u w/provider via PR. G0333 was not a problem with AME 10/14/13 SUN: G0333 has been updated in our system and this is in production now. Claim adjustments have been done for G0333 for this provider yesterday, although we are looking at this globally as well. 11/1/13 SUN G0333 Claim Project 028109 approved- expected resolution 11/22/13. 11/12/13 SUN: Claim project is completed. 119 claims reprocessed.
8/20/13 10/8/13	HP	B9998 T4521	Claims- HP	Being rejected by HP back to provider, even with EOB and claim detail provided	9/12/13 State researching w/HP 10/7/13 state- HP denied claims where Adjustment reason & group code were missing, working with provider to provide details on submitted claims 10/8/13 state- If primary RA code set is not HIPAA compliant, the provider can use this **form**, fill it out and send it in with the CMS 1500 claim form and EOB.

8/29/13*	UHC SUN AME	J7506 J7507 J7517 J7613	Claims- J code crosswalk Amerigroup Crosswalk projects worked codes 9/9/13 9/12/13 9/18/13 9/25/13 10/2/13 10/10/13	Not paying claims since January. J codes mainly rejecting by SUN as "bill to PBM". UHC recouping MCR crossover claims. Transplant children, zero claims payment since January. Have called local provider rep, no call back. Have been told by AME to send spreadsheet	9/6/13- SUN, J7507 Crosswalk updated retro to 10/1/2012. SUN to review claims. 9/10/13 UHC, We have claim examples and are reviewing each one currently. 9/10/13 SUN We are unable to locate any RX denials on J codes "bill to PBM". 9/12/13 AME, Investigating prior claims examples, PR Rep visit will occur in future w/current focus on outstanding claims 9/12/13 UHC, Some rates were incorrect, researching a claims project & have requested updates on codes. No ETA 9/12/13 SUN, J7613 denied for authorization required, developing a claims project, ETA 30-45 days. 9/12/13 SUN, J7507 valid NDC, reprocessing claims, ETA 30-45 days 9/24/13 SUN has reprocessed claims for this provider and reached out to other one. 9/12/13 AME, J code crosswalk updates being applied. Will re-sweep applicable claims by ETA 10/15/13 9/12/13 UHC, lesser of logic applied 9/12/13 State researching lesser logic policy & application 9/18/13 UHC claims being reprocessed for this provider by 9/19/13. The only other provider who submitted J7507 did not submit an NDC so claims were correctly denied. Rep will reach out to this provider. 9/24/13 UHC We did find claims that were priced incorrectly. Those claims were adjusted. We located 8 claims that had denied for future date billing. Those claims will need to be resubmitted by the provider. That information was communicated. 10/8/13 SUN,all J codes crosswalk project completion eta 11/1/13, then begin reprocessing 30-60 days 10/10/13 AME, J code NDC crosswalk complete for retroactive codes. Will continue to reprocess weekly for newly updated J codes. Will provide a list of completed NDCs.- provided 10/23/13 links attached 11/1/13 SUN Project 028089 is 98.8% complete. 11/27/13 SUN: Project 028089 is complete.

11/5/13	SUN	A4253	Claims-Overpayment	Paid claim at $20.82. correct amount due was 4.16	11/5/13 SUN, will recoup.
8/29/13*	UHC	J7644	Claims-Overpayment	January issues not resolved- overpayment needs recouped, no follow-up calls. These are crossover claims. Got 40.49, should've only received 9.47. Paying entire claim instead of only crossover amount	8/29/13 UHC- Crossover not being applied appropriately. Claims were overpaid. A letter out to providers next week for specific claims that were overpaid and need to be adjusted for provider to review 9/10/13 UHC working through the individual claims issues currently 9/24/13 UHC Letters were mailed to professional providers (DME included in this group of letters) on 9/18/2013. We are obligated by our contract with these providers to hold any recoupments for 45 days unless the waive that hold period in writing. Once the 45 day hold time has expired or the provider has waived that hold time it generally takes 30 days to initiate those claim recoupments. 10/24/13 reopened. Provider states reprocessed claims still are coming back as overpayments. UHC to follow-up. UHC - we spoke to provider on 10/24/2013. Her COB claims were processing incorrectly due to a unclear wording in the manual SOP used to work DME claims with Medicare primary. Her claim have been submitted for adjustment.

11/8/13*	All		Claims- Processing	What is the timeline for filing corrections and appeals.	11/8/13 SUN: SSHP correction is 180 days from date of EOP is primary, 365 days if secondary. Appeal timeframe is 180 days from EOP 11/8/13 UHC: This process information can be found in Chapter 15 of our Provider Administration guide, timeframes are in each providers contract with UHC. Claims corrections - The provider has 365 days from the date of service on the claim to submit corrected claims if the original claim was submitted within timely filing guidelines in their contract. This would apply to claims where the provider made an error on the original submission and something needs to be changed on the claim. Claims reconsiderations - The provider has 365 days from the date of service on the claim to request a claim reconsideration if the original claim was submitted within timely filing guidelines in their contract. A reconsideration is a claim where the provider believes they submitted the claim 100% correct and wants UHC to reconsider how we processed the claim. UHC Formal Claim Appeal – A provider has 30 days from the date on the provider remittance advice to submit a formal claim appeal. State Fair Hearing Request – A provider has 30 days from the date of the negative action (for claims this is generally the date of the denial on a Provider Remittance Advice), plus 3 days mailing time, to submit a state fair hearing request. 12/2/13 AGP | This information is in our provider manual, Chapter 3. Some provision are modified on a contract by contract basis (timely filing limits as an example) so providers should also refer to their contractual documents for variation. Generally, claim corrections must be filed within the timeliness requirements for clean claim submission - for DME providers in the Kansas market that is 90 days - a unclean claim submission does NOT reset the timely filing start date - the start date continues to be the date of service. First level appeals must be submitted within 90 days of the paid/denied date on the explanation of payment; second level appeals must be submitted inwriting and within 30 days of the first level appeal resolution date.

8/29/13*	SUN AME	Q0513	Claims- Q codes	Medicare crossover, Q-code being ignored but allowed by MCR. Q-dispensing fee but also a part of the cost of the medication. What is the plan for reprocessing Q codes once they are corrected?	8/29/13- UHC will automatically identify claims paid or denied in error 9/10/13 SUN, SSHP has run a project in June to reprocess for Q Codes but it appears allowed amount may be incorrect. Reprocessing will be necessary. We identified one Q code claim that was pending and are releasing. 9/10/13- UHC have spoken with provider and indicated no issues with UHC at this time. Provided him with direct contact information for his Provider Advocate for any future issues. 9/12/13 SUN, Q0511, Q0512, Q0513. Codes defaulted to incorrect payment amount. Reviewing data to capture all claims. 10/7/13 SUN: For Medicare crossovers, system reconfiguration will be necessary. We are applying State Medicaid rate, not MCR rate, still being researched. For any other primary payer, Q0511-Q0513 system reconfiguration work completed on 9/24/13. 10/21/13 AME: Project scoping/report project submitted ECD 10/25/13 for Q0513. Total sweep project submitted on return of report. 10/29/13 SUN: Medicare Crossover CR pending. 11/18/13 SUN: CR work continuing. 11/25/13 AGP | Project submitted for prioritization and adjustment - ECD 12.20.13 12/2/13 SUN: Targeting release of CR to update system 12/6/13.

9/25/13*	AME SUN	J0696 J1335 J3370 G18 J7507	Claims-Reprocessing	Claims reprocessing incorrectly	10/14/13 SUN: J7507 System update pending for claims when SSHP is secondary to Medicare. 10/15/13 SUN: Reached out to provider yesterday and identified a few more claims to review. We have a standing meeting with provider scheduled for 10/17/13 and will address on that call. 10/21/13 AME: J-codes reprocessed, G 18 denials working configuration to allow payment- no project until configuration complete 10.21.13 AGP | Claim project submitted for identified claims. ECD 10.29.13 11/1/13 SUN Project 028089 is 98.8% complete 11/18/13 SUN: Status unchanged. 11.25.13 AGP | General project completed. Research analyst assigned to complete clean up of all residual items. ECD - 12.23.13 12/2/13 SUN: Project 028089 is complete.
8/29/13	UHC SUN AME	All	Claims-reprocessing	Are fixed issues going to be reprocesses for all providers, or does each provider have to reprocess each claim since January?	8/29/13 Providers shall be notified, and the MCO shall reprocess the erroneous claims 10/22/2013 - UHC is reprocessing all claims impacted for our global issue. This would include claims back to 1/1/2013.
9/25/13	SUN	A4215	COB	Rejecting L6, submit to primary 1st	9/26/13 Researching Med B vs. Med D and COB coverage quidelines 9/30/13 Syringes and Pen Needles are a Part D benefit. Providers should submit these codes to Part D 1st, not Part B

10/10/13 *	AME	A4215 A4206	COB	Part D copays for Pen needles and syringes being denied by secondary	10/10/13 AME- Pharmacy side, will research 10.21.13 AGP | We have determined that small DME items are not set up for Med D copay assistance. We are in the process of adding these to the Med D formulary. Caremark is working with provider to reprocess these claims - ECD TBD for both aspects. 12-03-2013 AGP | Caremark begins testing of updating the changes to the Med D covered drug list under the pharmacy benefit to include DME items.

8/29/13*	UHC SUN AME	A4253	COB	Everything rejecting. Different reasons. Crossover does not work at all. Utilized website and received a call stating she had to use Emdeon. That didn't work, have tried KMAP, then rejecting again for a new reason. Have followed KMAP provider guidelines and still being rejected. Need to know what needs PA now that was covered before. PA limits from before don't seem to apply now. Need to know guidelines prior to dispensing. Wants ph# for each provider esp. for DME issues. Who are the DME providers for KS to refer patients, where is that info available ie- wheelchairs, breast pumps, nebulizers?	8/29/13 SUN, refer pts to benefit plan for a provider referral for other DME services that you do not offer. 8/29/13 UHC, call member services 1-877-542-9238 to locate a provider 8/29/13 State survey of DME providers for reference by the MCO possible, State working to provide more concise, thorough contact documents 9/24/13 Contact pages posted on the KanCare Website here: http://www.kancare.ks.gov/pharmacy.htm 8/29/13 www.Uhccommunityplan.com provider info page, provider forms, PA form HERE 8/29/13 AME, call member or provider services 9/24/13 SUN- issue relating to 250.0 and the KS and KX modifier. These claims will be reprocessed as a claims project. 10.7.13 AGP A4253 denying for this provider is correctly denied due to failure to obtain pre-auth - provider is non-participating with AGP. 9.26.13 | No further AGP action required. 10/7/13 SUN: Claim project is still being worked on. 10/8/13 UHC system project for A4243 completed 9/7/13, eta for claims adjustment completion is 11/8/13 10/10/13 UHC, New DME COB policy for Medicare –regarding, Medicaid secondary claims not processing/paying as expected- the system was corrected on 10/1. We are in the process of getting the adjustment project worked. Expected ETA should be mid to late November. 10/22/2013 - UHC - the claims adjustment project for A4253 should be completed by 11/15/2013. Erroneous Maximum frequency per day denials. 11/1/13 SUN: Project 028097 88.2% complete. 11/18/2013 - UHC - claims billed with A4253 that denied for maximum frequency per day for par providers have been adjusted. Those adjustments completed 11/12/2013. Please note, claims for non-par providers are still in process. 11/12/13 SUN: Project complete. 4611 claims reprocessed. 11/27/2013 - UHC - The ETA for claims for non-par providers is 12/31/2013.

8/29/13*	AME	S8490 KX-mod	COB	Crossover claim from MCR to AME for syringes requesting EOB	10/4/13 AGP | The NCC information provided to the provider was correct, and the claim correctly denied. The member has commercial insurance as primary and an EOB must be submitted with the claim. On a call with the providerr, the procedure for submitting EOB information was covered - the next action required is on the part of the provider. No further action on AGP's pert.
8/29/13*	SUN UHC AME	A4253	Date Spanning	Date spanning not allowed by MCO's but used by Medicare on testing supplies. Having to rebill to MCO then being denied for another issue.	8/29/13 SUN needs claim ID detail, email to bswan@sunflowerstatehealth.com 9/10/13 UHC has requested claim detail but has not received it 9/11/13 AME is running an overall comprehensive review of claims and this providers set up to determine factors related to their outstanding questions 9/24/13 UHC's system cannot accommodate claims with future dates. Providers can either wait until the dates on the claim are no longer future dated, or they can submit the claims with the from/to date as the date the supply was dispensed. 10/22/13 AME does not accomodate claims with future dates. 10/22/13 SUN does not accomodate claims with future dates

8/29/13	SUN AME UHC	All	Duplicate claim	Medicare claims billed based on date of delivery. MCOs rejecting as “duplicate claim” when the date of delivery is prior to the end date of service for previous claim. Member cannot wait until the day the new therapy is to start for home delivery. What are the guidelines for billing a service prior to the end date of service on the previous claim? Provider following MCR guidelines for billing as date of delivery. Have several claims denied saying “duplicate claim” but there is no duplicate claim listed on the website, why denying?	8/2/13- UHC Needs specific claim detail. If a claim is filed multiple times, then may be denying on previously denied claims. Will reach out to provider for specific example. 9/10/13- UHC is working to resolve the issues with this member’s claims. 10/7/13 AGP | Denied as duplicate claims resulted from analyst error in applying the appropriate payment rules. Denied claims will be reprocessed by 10/28/13. AGP spoke with provider on 10/3/13. 10/8/13 - UHC - we have reprocessed and resolved all claims issues for this provider. We spoke with this provider on 9/19 and she confirmed that she has no outstanding issues with UHC. 10/21/13 AME: 10/31/13 ecd on project completion

8/26/13	SUN AME	648.80	Dx	gestational diab, 648.80, recd test strips 1/26/13 & 2/15/13, rec'd inappropriate Dx denial.	8/27/13 SUN identified a configuration issue & working to address 9/9/13 SUN claims submitted for reprocessing, monitoring 9/24/13 SUN claims reprocessed. 10/7/13 SUN: Continuing to work with provider, down to three claims at issue. 10/8/13 AME: We did receive the policy and it was distributed internally at that time. We've reviewed our configuration and have some additional work to do to comply. Our estimated date of completion for this policy is 11/3., also researching other Dx in this policy. 10/24/13 SUN, provider states no further issues with SUN. 11/18/13 SUN: 15 claims billed with dx 648.80 discovered. Claims submitted for reprocessing. 12/2/13 SUN: Claims have been reprocessed. 11/25/13 AGP | Project submission ECD 12.6.13 - 2 week ECD for completion.
9/12/13*	UHC SUN AME	All	Log	Provider issue logs not easily accessible or searchable	10/1/13 Issue log has been converted to Excel for easier navigation. Amerigroup: https://providers.amerigroup.com/ProviderDocuments/KSKS_KnownIssuesLog.pdf Sunflower: http://www.sunflowerstatehealth.com/files/2012/06/Sunflower-State-Stakeholder-and-Claims-Issues-Log-091013.pdf United: http://www.uhccommunityplan.com/health-professionals/ks.html State DME Stakeholder log: http://www.kancare.ks.gov/download/KanCare_Known_Issues_DME.pdf State Rapid Response Stakeholder Issues Log: https://www.kmap-state-ks.us/documents/content/KanCareIssueLogs/KanCareIssueLogs.pdf

9/26/13*	SUN	All	Log	Archived issues logs back to January, providers need access to old claim issues	http://www.sunflowerstatehealth.com/for-providers/provider-resources/
10/23/13	UHC	E0443	Manual pricing	Secondary claims rejecting	UHC - we spoke to provider on 10/29/2013. Two COB claims were priced incorrectly. This was manual processing error. We will provide education to the claims processor and have the claims adjusted for the provider

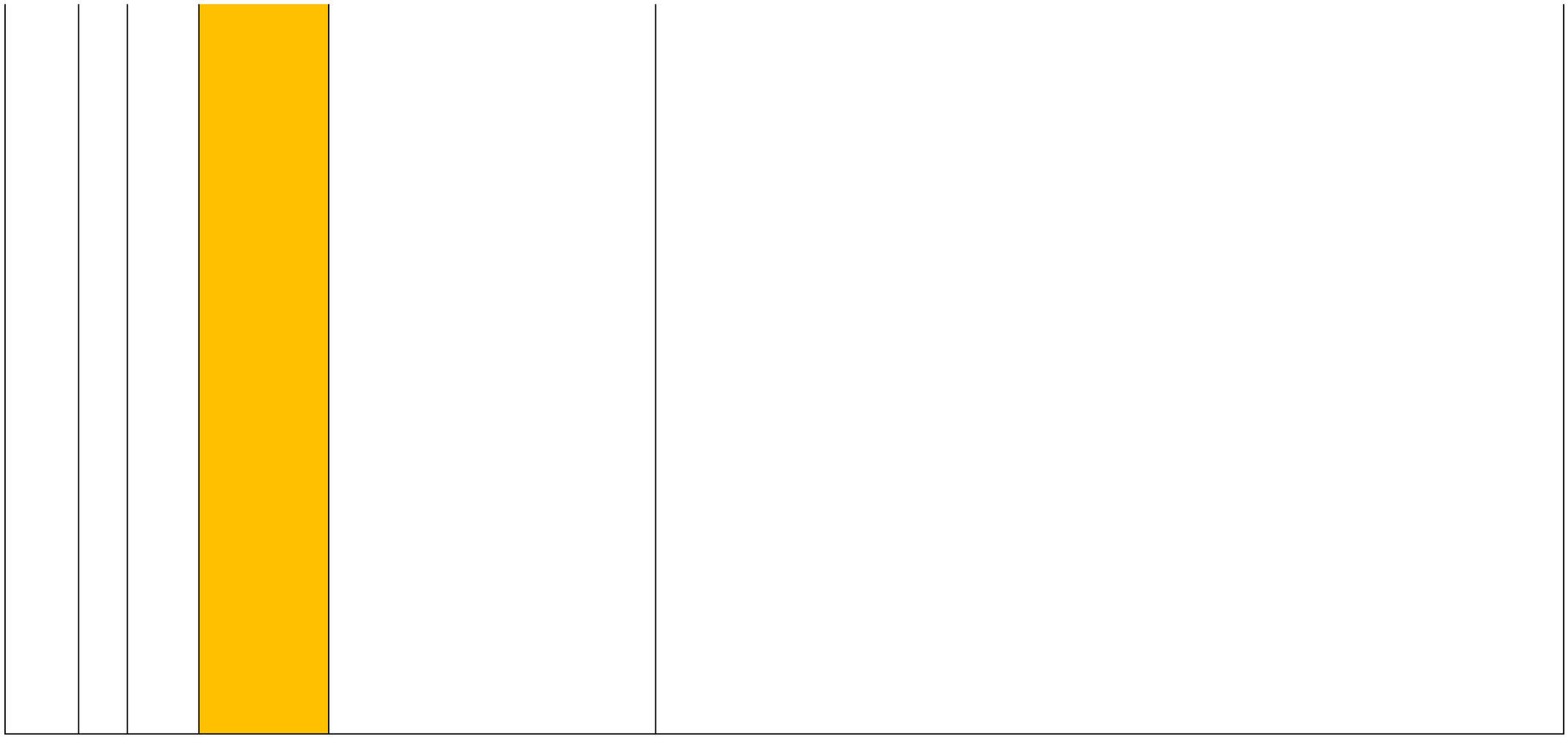
8/23/13	SUN UHC AME	K0004 K0052 K0019 E2206 K0077 K0108 K0739 343.8	Manual pricing	Provider gets PA approved, then service is denied or paid in full at $0 If a PA is approved, no $ approved amount is given. Eligibility is not being checked during the PA approval process. The right boxes are not on the PA form for SUN. WC payment denied, field rep came out & explained they were going to help the member fill out an application for CP funding rather than the MCO paying. Non-coverage of TENS unit, repairs, oxygen, wheelchairs **PROVIDERS: For PA issues, refer to PA section. Responses here apply mostly to manual pricing.**	9/11/13 State, K0052, K0019, K0077 are QMB covered only. 9/11/13 SUN, E1399 requires invoice to price 9/12/13 SUN, K codes, some codes loaded incorrectly, reprocessing claims with wrong determination, ETA 30-45 days 9/12/13 AME, wheelchair codes manually priced at 75% MSRP standard, many were denied, going back to re-price & will reach out to providers., wheelchairs are it's own project based on MSRP. 9/24/13 UHC Manually priced DME codes not paying correctly – This correction requires three tasks. The first task is completed. The second task, which is creating an SOP for use by the claims team is in the final stage of approval. The third task, create a specific pending queue for these claims to route to in order to ensure the correct processing is the last task and it is in process. I am waiting and an estimated completion date on the third task. 10.4.13 AGP | Provider outreach and claim project complete for claims with sufficient information to reprocess. AGP will complete processing on claim corrections / resubmissions as they occur. 10/7/13 AGP- K0004 Manual pricing project, repriced all with MSRP data- PR team outreach to others without data submitted with claim (correct denials) for resubmission 10.07.13 AGP | Call placed to provider to review any additional outstanding issues. 10/7/13 SUN: System reconfiguration will be necessary. 10/8/13 SUN update, there is no claims project on manual pricing, calculation by MSRP is done case by case. 10/8/13 - UHC - We expect the system configuration for DME manually priced codes to be completed by 10/25/2013. Once the system has been updated and tested a claims project will be submitted. 10/14/13 SUN: No project in place. If Medicaid rate indicates manual pricing, these claims pend in our system to pay at 75% of MSRP.Otherwise we would follow KMAP allowed amount if not manual. 10/31/13 UHC - the system correction was delayed to 11/15/2013. However we have submitted a project to begin to adjust DME manually priced codes using the completed SOP. Claims with dates of service 1/1 to 10/27 are being included in this project and the estimated completion date for this project is 12/15/2013. 11/18/2013 - UHC - These claims are now dropping for manual review (11/15/2013). We are process of doing production validation this week to ensure claims are dropping correctly and being worked correctly using the SOP. An adjustment project has been submitted to reprocess these claims, however if the provider did not submit the original claim with an invoice, the claim will deny when adjusted. The provider will need to submit a corrected claim with an invoice attahced in order for the claim to process correctly. 11/27/2013 - UHC - New day claims billed for manually priced DME codes should now process correctly if submitted with the invoice. The invoice is

					required for accuarte payment of claims. The adjustment project for claims previously paid or denied in error is schedule to be completed by 12/31/2013. Please note, many of the claims going through the adjustment process will deny, resulting in a recoupment for the original incorrect payment amount due to no invoice. Providers will need submit corrected claims to UHC with the invoice attached. 11/27/13 SUN: Provider Rep verified claim is at issue and we are researching. 12/2/2013 AGP | Adjustable claims have been resolved. Have scheduled follow-up for any required residual actions.

8/29/13	UHC	E1390RR E0431RR	PA- changed	Paid fine January-July, now stating that it needs a PA.	9/11/13 UHC PA is required. We had a PA waiver in place between 1/1/2013 and 5/31/2013 due to the continuity of care period. Our standard prior authorization requirements went into place on 6/1/2013. We indicate in our Provider Administration Guide (PAG), chapter 4, that all oxygen services requires a PA. Here is a link to this document: . http://www.uhccommunityplan.com/kansas-03.html , chapter 4.
8/29/13*	SUN	K0003 E0601	PA- changed	Wheelchair PA by KS last year. One month covered, next mo not covered, and then covered.	9/5/13 SUN, E0601, verified this is covered KBH members only 9.26.13 | AGP - Review on-going results expected in early October.
10/8/13	ALL	E0118RR & others	PA- eligibility	Member eligibility (benefit plan) not being verified for PA requests. Item requested may have benefit plan restrictions, not being verified for PA requests.	10/10/13 Providers should verify which benefit plan the member is enrolled in at: https://www.kmap-state-ks.us/PROVIDER/SECURITY/logon.asp If the member has standard Title XIX, the provider should then verify coverage of the item at: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp using Title XIX as the benefit plan, Provider Type/Specialty 25-250. The reason for this is some items are only covered for QMB patients and this process will help determine 1- if the member is QMB or Title XIX, or Medikan, and 2- if the item is covered for Title XIX, or JUST QMB.

8/29/13*	UHC AME SUN	All	PA- forms	PA and DME form. Which form to use? Put DME PA form on KanCare or each MCO website	8/29/13 State- updated KanCare Pharmacy Provider page to include direct link to DME PA forms separate from Rx PA forms. http://www.kancare.ks.gov/pharmacy.htm 8/29/13 State- Guidelines for coverage can be found via provider manuals for each MCO. http://www.kancare.ks.gov/pharmacy.htm seeking more specific documents. 9/10/13 UHC- We have claim examples and are reviewing each one currently. 9/24/13 SUN-We have met with provider via conference call and are working directly with provider to resolve issues. 10.8.13 AGP | Although AGP has been in contact with members of the pharmacy staff as late as 9.27.13 - on a call this morning AGP will arrange a face-to-face meeting with staff for the week of 10.14.13 to review remaining claim issues and discuss next steps/actions required. 10/8/13 - UHC - We have resolved provider's issues. 8 of her denied claim will have to be resubmitted to UHC as corrected clams in order for her to receive payment. That was communicated to her on 9/24/2013.
11/5/13	AME	E0600	PA- no PA on file	Website states no pre-certification required, but claim denies for no auth on file. Appeal denied	11/7/13 Researched and resolved

8/29/13*	SUN UHC AME	J7644 J7613 B4189 B4193 B4197 B4199 B9004 B4224 E0781 A4222	PA- no PA on file (will insert AME Auth table here when available) Sunflower J Code-NO Auth Project List HERE	Denial- "Authorization not on file" for crossover albuterol claim. Should be a covered service, MCR covered it. Direct KMAP claims not an issue, just crossover Inconsistent PA requirements now vs. FFS, and also from month to month within the MCO Denials as non-covered. Inconsistent payment. Crossover issues. PA status changes & recoupment. Outstanding claims from January. Sub-par communication standards by MCOs.	8/29/13 SUN Needs claim detail to reprocess claim. Have a claims project for COB issues for "authorization" issue but will address this specific claim quickly 8/29/13 SUN Email a copy of past authorization to bswan@sunflowerestatehealth.com for PA problems. 9/4/13 SUN, both claims submitted for reprocessing today 9/5/13 SUN, Primary PA rules apply and if they allow/pay no PA required. Also addressed SSHP PA requirements in general. 9/12/13 SUN, J7644 denied as non-covered code, not determined of global yet, No ETA 9/24/13 SUN: These two claim examples have been reprocessed and paid. 9/24/13 SUN Conference call held with provider (#4). All claims issues reported by provider during call are being worked today to target 9/27 Friday payout 9/24/13 UHC We were able to locate the claims and assist her with finding them on her remittance advice. All three claims had paid. We did not see and duplicate denials for her claims. 9/24/13 UHC DME claims denying for no PA in error – Our system was corrected as of 9/23/2013. We are in the process of getting a claims adjustment project submitted for all impacted providers, no ETA 10/7/13 SUN: Claims presented to us on 9/24 /13 call have reprocessed, two denied for exceeding auth limit. We have a standing meeting with provider (#4) and will continue to address issues. 10/8/13 - UHC - we have reprocessed and resolved all claims issues for this provider. We spoke with oen of these providers on 9/19 and she confirmed that she has no outstanding issues with UHC. 9/24/13 SUN-Sunflower has waived PA requirements on certain J codes effective 5/1/13. This may account for differing processing. It has been decided to launch a global project for all providers to reprocess back to 1/1/13. 10/3/13 AGP Claim project submitted for reprocessing of affected claims - project ECD is 10/21/13. 10/8/13 SUN, claims project underway for J codes denied for authorization in error, PA requirement rescinded 5/1/13, reprocessing claims back to 1/1/13, project eta 11/1/13, claims reprocessing 30-60 days 10/8/13,UHC • DME claims denied for no PA in error – the system was corrected on 9/23. We are in the process of getting the adjustment project worked. Expected ETA should be mid to late November. 10/8/13 AME based on Authorization tables from August, some codes were denying as needing PA in error, adjustment project completion eta 10/31/13 10/21/13 AME: B4193 & B4197 (AME affected codes) project complete UHC - 10/22/2013 - All DME claims/codes denied for no PA in error have been adjusted as of 10/21/2013. Provider should see those adjusted claims on a RA in the next 5-7 business days. 10/29/13 SUN: CR for J7644 expected to be completed by 11/15/13. Claim Project will be needed. 10/29/13 SUN: J7613 is part of Project 028089, 85% complete. 11/7/13 Provider states B9004 still not paying from AME. 11/7/13 we did have a project for claims that denied for NDC code in error (project 028083 that was completed 10/23) including 90376, A4216, A4217, B4189, B4193 11/18/2013 - UHC - Claim for PAR providers completed adjustment on 11/8/2013. Claims for non-par providers are still in process. I do not have an estimated completion date at this time. 12/3/2013 - AME- this effort is wrapped in overall cleanup effort described in previous items.



9/12/13	SUN	B9002RR	PA- not needed	Several claims B9002RR 1/1/13-6/1/13 paid. PA requirement on SUN website said "NO". Also several documented correspondences between provider and SUN where Sunflower verified that NO PA was necessary. (Enteral Nutrition Infusion Pump Rental)	9/18/13 SUN We are reprocessing the claims and should be done by 9/30 or sooner. 9/25/13 SUN All claim issues reported by provider during call are being worked today to target Friday 9/27 payout. 9/26/13 SUN this is code specific as it was first brought up by provider but we are running the project for all providers, claims project complete eta 11/1/13, claims reprocessing 30-60 day eta completion 11/1/13 SUN: Project 028089 98.8% complete. 11/12/13 SUN: No change. 98.8% complete, 1290 out of 1306 claims reprocessed. 12/2/13 SUN: Project 028089 is complete.
8/29/13	UHC SUN AME	All	PA- Primary Payer	When MCO is primary payer, clarify DME PA requirements for each MCO, for each item. Be more specific than general provider manual. What guidelines are being used? Is payment based on billed amount or fee schedule? If MCO is secondary payer to Medicare, do primary payer rules apply?	9/4/13 SUN, If primary pays or allows, SSHP PA rules would not apply 9/11/13 State, working with each MCO to identify DME guidelines accessible to providers 9/11/13 UHC, For most DME supplies we only require a PA for services when the billed charge for the item is more than $500.00. There are a few supplies that are exceptions to this policy and they are specifically called out in our PAG. We will be happy to walk through that with providers. Link here: http://www.uhccommunityplan.com/assets/KS-Chapter4-MedicalManagement.pdf 9/26/13 State will clarify primary payer rules 10/7/13 AGP | In response to state's question: AGP requires a PA if the primary payor denies the claim because the service being billed is non-covered; if the member's primary payor plan covers the service (even if the payment is zero or the claim is denied because benefits are exhausted) AGP is secondary and will not require a PA. 10/7/13 SUN: Advised provider of our PA requirements by sending this bulletin from December 2012: http://www.sunflowerstatehealth.com/files/2012/12/Fax-Blast-12-20-12.pdf?723da5 10/7/13 primary payer rules are referenced in E2012-036. 10/8/13 UHC • New DME COB policy for Medicare – the system was corrected on 10/1. We are in the process of getting the adjustment project worked. Expected ETA should be mid to late November. 11/18/2013 - UHC - We only require a PA on DME services/supplies if the line item billed charge exceeds $500.00. The only exception to this rule is for powerwheel chairs and wheelchair accessories. If a member has Medicare as a primary payer we would only require a PA if the service is non-covered by Medicare and UHC would be the primary payer.

10/10/13	SUN AME	E0791RR	PA- Primary Payer	Website states pre-certification requried, when provider sends paperwork for pre-certificaiton, they receive notice back stating no pre-certification required if patient has Medicare primary, but Medicare does not cover this service. Web detail does not match the notifications the provider receives back.	10/10/13- PROVIDER: please provide documentation for SUNFLOWER claim so we can research 10/14/13 SUN: If primary does not cover, SUN PA rules apply. Provider should obtain PA. SUN will educate internally. 10/21/13 AME- under research 10.21.13 AGP | Using detail submitted - AGP is activating an authorization for the service requested; working to re-educate staff on appropriate response. ECD for authorization entry 10.23.13 - provider will be able to submit claim for payment at that time. 12/2/13 AGP: Claim submitted and paid.
9/26/13*	AME SUN UHC	ALL	Provider Issue	How to get DME issues from pharmacy providers to the State?	http://www.kancare.ks.gov/pharmacy.htm
8/29/13	AME	All	Provider Issue	Lack of provider rep responses to inquiries	Addressing
8/30/13	UHC	All	Provider Issue	Provider not listed on the print or on-line version of the provider search for DME	9/12/13 UHC still working to resolve the problems with the on-line look-up tool 9/26/13 the issue with the on-line directory is corrected and it is now functioning correctly 10/25/13 UHC: UHC can only list a provider in the directory with their primary provider specialty, which is DME.

8/29/13	AME	TBD	Provider Issue	PXN reject “paid per contract Out-of-Network” rates, but they are an in-network provider	9.26.13 | AGP is paying 100% of Medicaid for both PAR / NP provider's there would effectively be no difference in pricing at this point in time. The AGP explanation code PXN is "NetworX Std Fee Sched" … and does not reference OON/IN status.

8/29/13	SUN UHC AME	A4253	Supply Limit *Sunflower max allowed project worked codes here	Supply limit denials	9/12/13 SUN, known pending claim issue, pending system configuration update, No ETA 9/12/13 UHC, configuration issue for max/day, October 1 ETA. 9/12/13 AME, AME was applying DME supply limits as Industry standards in lieu of state criteria, unless there was a state specified limit. This is being reviewed. 9/24/13 AME will be applying limits where those are specifically addressed in the KMAP grid 9/24/13 UHC The system configuration to update this was completed on 9/7/2013. We are in the process of getting the claims adjustment project completed. 9/26/13 SUN- send A4253 box limit denials to bswan@sunflowerstatehealth.com or the State fax 785-296-4813 9.26.13 | AGP - Review on-going results expected in early October. as of 10/8/13 no ecd. 9/30/13 SUN: regarding one box limit, addition system updates identified & in progress. Reprocessing of all affected claims will be completed by 11/1/13. 10/8/13 UHC • We continue to research DME codes that are hitting the maximum frequency per day limitations to validate accuracy. If our research shows issues we will initiate system configuration corrections and projects 10/8/13 UHC • A4253 – the system was corrected on 9/7. Estimated completion date for the claims adjustments is 11/8. 10/10/13 A4253, provider states 9/23 claims still denying for UHC. 10/10/13 AME A code projects complete. this issue was primarily related to the application of limits. AGP realigned our industry standard limitations to the KMAP table of limitations. We reprocessed the A-codes (as well as other codes with limitations) that were primarily affected by those limitations (A4253 is exemplary of several codes). Similar to United the project was not code dependent but rather focused on our denial codes when denying claims for service limits. The code listed on the log was specific to issues this particular provider was having while the solution was more broadly applicable 10/10 13 UHC • We continue to research DME codes that are hitting the maximum frequency per day limitations to validate accuracy. If our research shows issues we will initiate system configuration corrections and projects 10/16/13 SUN - Project EX35 benefit maximum reached project has been submitted. The project spans from 1/1/13-10/16/13 and encompasses 4611 claims. Expected resolution date is 10/31/13 but is subject to change. Code list link in column C. 10/22/2013 - UHC - the claims adjustment project for A4253 should be completed by 11/15/2013. Erroneous maximum frequencey per day denial. 11/1/13 SUN: Project 028097 88.2% complete. 11/18/2013 UHC – Not currently seeing a global issue with A4253 denying for maximum frequency per day. 11/12/13 SUN: Project complete. 4611 claims reprocessed.

11/7/13	UHC	E0463 E0464	Supply Limit *Sunflower max allowed project worked codes here	Claims rejecting for maximum frequency per day in error.	11/7/13 requires policy clarification and subsequent system correction 11/18/2013 - UHC - this will require a change in system configuration to fix this for 100% of claims billed for A0463 and A0464. The estimated completion date for this configuration is 12/1/2013. Once the system is corrected we will initiate and adjustment project. 11/27/2013 - UHC - We received the policy clarification this week. It documents that these codes are 1 unit = 1 day. System configuration is completed for E0463. We are waiting on confirmation of E0464. There were additional codes on the policy that will need to be added to our work.
8/29/13	UHC SUN AME	All	Untimely filing	Rejections of “untimely filing”. Resubmissions are not being attached to original claim and being rejected. Known issues are also being rejected as untimely. Claims rejected as untimely filing when >180 days old.	9/9/13 SUN, requesting list of claims as it sounds like these were not recognized as corrections or appeals. 9/10/13 Have recommended provider send specific claim examples to Bryan Swan BSWAN@sunflowerstatehealth.com 9/11/13 UHC, When a provider submits a corrected claim or resubmits a claim they do need to submit that new claim with the original claim number in the appropriate field in order for the resubmitted or corrected claim to process correctly. If they are following that process and claims are still not processing correctly we would need to review those to identify why the claims are not processing correctly. 9/24/13 SUN-We have reprocessed J1642 claims, E0780 claims and B9998 claims 10/7/13 AGP | In response to the state's question, timely-filing is being waived when known issues may have impacted claims submission or adjudication. In other cases, AGP makes a decision based on the specific conditions affecting the provider. 10/8/13 SUN: Provider contacted and providing examples to PR Rep. Provider contending timely filing on SSHP primary claims should be 365 but our timely filing is 180. We do afford 365 days when we are secondary. 10/22/13 UHC: If a provider has claims that were filed following UHC's process to bypass timely filing denials and still had claims denied for not timely filed. They can work with their Provider Advocate to have those claims adjusted.